Health Services
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To improve health through leadership, service and education.

September 15, 2008

TO: Each Supervisor

FROM: John F. Schunhoff, Ph.D.
Interim Director

SUBJECT: **DEPARTMENT OF HEALTH SERVICES (DHS) – FISCAL OUTLOOK – SEPTEMBER 16, 2008**

This is to provide a Summary of Changes in the Department of Health Services' (DHS) Fiscal Outlook (Attachment I) since our last Budget Committee of the Whole report to your Board on June 17, 2008, and a Budget Plan (Attachment II) to address the estimated shortfalls of ($43.7) million for Fiscal Year (FY) 2008-09, and ($360.5) million for FY 2009-10. If potential revenue solutions and efficiencies identified by the Department (Attachment III) are fully realized, the budget deficits are estimated at ($8.9) million for FY 2008-09 and ($107.7) for FY 2009-10. These estimates do not include potential State Budget cuts in the Safety Net Care Pool, SB 474 funding (South Los Angeles Medical Services Preservation Fund), or other unanticipated cuts.

After a thorough review of the potential options for resolving the budget deficits in FYs 2008-09 and 2009-10, the Department developed the attached Budget Plan. The Budget Plan describes the Department's approach to developing the recommended actions, and specifies the various efficiencies, service reductions, and potential revenue and funding solutions which will be necessary to implement in order to responsibly plan for and manage these anticipated shortfalls.

Based on State budget impact and any additional changes in revenue projections or efficiencies, the fiscal forecast will be revised and provided with the Budget Plan for your Board's approval in January 2009.

If you have any questions or need additional information, please let me know.

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Attachments (3)

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors

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COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

SUMMARY OF CHANGES IN THE DHS FISCAL OUTLOOK

JUNE 9, 2008 THROUGH SEPTEMBER 4, 2008

		Fiscal Year / $ In Millions					
		07-08	08-09 (C)	09-10 (C)	10-11 (C)	11-12 (C)	Total
(1)	**Estimated Cumulative Year-End Fund Balances/(Shortfalls) - 6/9/08 (A)**	**$ 108.1**	**$ (213.5)**	**$ (589.6)**	**$ (1,039.1)**	**$ (1,443.8)**	**$ (1,443.8)**
	Adjustments Included In Supplemental Budget Resolution (SBR)						
(2)	Adjustments to CBRC revenue (hospital only) to include "crossover" patients with dual eligibility on Medicare and Medi-Cal programs (D)	-	96.4	24.5	28.2	29.3	178.4
(3)	Measure B Funds COLA (DHS share) - approved by the Board in August 2008 (E)	-	36.8	36.8	36.8	36.8	147.2
(4)	Financial Stabilization updates	(6.5)	15.6	13.0	13.0	13.0	48.1
(5)	Use of one-time Tobacco Settlement funds (already included in Board Adopted Budget)	-	44.8	-	-	-	44.8
(6)	Use of one-time Measure B reserves (already included in Board Adopted Budget)	-	32.0	-	-	-	32.0
(7)	Realignment of Vehicle License Fee and Sales Tax per the CEO	(6.5)	(6.0)	(6.0)	(6.0)	(6.0)	(30.5)
(8)	Loss of CHIP revenue (per Governor's May Revised Budget as of 5/14/08)	-	(5.3)	(5.3)	(5.3)	(5.3)	(21.2)
(9)	Adjustment to MLK's estimated ADC (for FY 09-10 only) when re-opening MLK as a hospital (F)	-	-	16.1	-	-	16.1
(10)	Indemnity and litigation charges per FY 07-08 actual (one-time adjustment)	12.5	-	-	-	-	12.5
(11)	Use of one-time Tobacco Settlement funds for Public/Private Partnership (PPP) capital infrastructure and capacity development in under equity areas throughout the County	-	(3.5)	-	-	-	(3.5)
(12)	Other adjustments	3.2	-	(1.8)	(8.2)	(7.6)	(14.4)
(13)	Forecast improvement/(reduction) roll-forward	-	2.7 (B)	213.5 (B)	290.8 (B)	349.3 (B)	-
(14)	**Adjusted Estimated Cumulative Year-End Fund Balances/(Shortfalls) - per SBR (A)**	**$ 110.8**	**$ - (G)**	**$ (298.8)**	**$ (689.8)**	**$ (1,034.3)**	**$ (1,034.3)**
	Developments Subsequent to / Other Adjustments not Included in SBR						
(15)	Medi-Cal Redesign revenues updates (H)	-	(0.8)	21.4	32.7	13.1	66.4
(16)	Medi-Cal administrative days revenue (I)	-	10.2	2.4	2.4	2.4	17.4
(17)	Potential revenue growth for Medi-Cal Redesign revenues (J)	-	9.4	21.9	33.4	42.7	107.4
(18)	CBRC revenue updates (K)	-	(18.2)	(15.7)	(12.8)	(14.8)	(61.5)
(19)	Revised estimates for CBRC revenue for the "crossover" patients as stated in #2 above (L)	-	(14.2)	(2.6)	(1.7)	(2.1)	(20.6)
(20)	Medical School Agreements (USC and UCLA currently under negotiations)	-	(14.8)	(18.9)	(22.6)	(26.5)	(82.8)
(21)	CHP out-of-plan costs	-	(4.7)	(4.8)	(5.0)	(5.1)	(19.6)
(22)	Implementation of the Plan of Correction at OV/UCLA in response to the EMTALA citation (M)	-	(4.3)	(4.4)	(4.6)	(4.7)	(18.0)
(23)	Electronic Health Record (EHR) Pilot Initiation	-	(3.0)	(11.0)	(2.9)	(2.5)	(19.4)
(24)	Emergency Department Automation	-	(2.8)	(5.3)	(1.4)	(0.7)	(10.2)
(25)	Enterprise Laboratory Information System	-	(1.2)	(2.3)	(2.3)	(2.4)	(8.2)
(26)	Transfer of LAC+USC's psychiatric outpatient clinic to DMH (expected effective date: January 1, 2009)	-	0.7	1.3	1.3	1.3	4.6
(27)	Forecast improvement/(reduction) roll-forward	-	- (B)	(43.7) (B)	(61.7) (B)	(45.2) (B)	-
(28)	**Revised Estimated Cumulative Year-End Fund Balances/(Shortfalls) - 9/4/08 (A), (N)**	**$ 110.8**	**$ (43.7)**	**$ (360.5)**	**$ (735.0)**	**$ (1,078.8)**	**$ (1,078.8)**

ATTACHMENT I

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

SUMMARY OF CHANGES IN THE DHS FISCAL OUTLOOK

JUNE 9, 2008 THROUGH SEPTEMBER 4, 2008

Notes

(A) This assumes CBRC will be extended for each year beyond FY 04-05. CBRC extension for LA County's outpatient and clinic care was included in the FYs 05-06 through 07-08 Adopted State Budgets. A Medi-Cal State Plan Amendment (SPA) to extend the program is currently pending CMS approval. FYs 10-11 and 11-12 assume Medi-Cal Redesign 1115 Waiver extension and continuance of its Coverage Initiative component.

(B) These amounts represent the cumulative change in the forecast from the prior fiscal year. For example, the $(45.2) million on Line# 27 in FY 11-12 is $735 million - $689.8 million from FY 10-11.

(C) For FYs 08-09 through 11-12, amounts reflect LAC+USC Medical Center as a 671 bed facility. For FYs 09-10 through 11-12, amounts reflect MLK MACC converted back to a 120-bed (73 ADC for FY 09-10 and 108 ADC for FY 10-11 and onward) public hospital on January 1, 2010 and Rancho Los Amigos National Rehabilitation Center not operated by the County.

(D) DHS has received acceptance from CMS in August 2008 for the inclusion of the Medicare/Medi-Cal (medi/medi) dual eligible visits as an allowable reimbursable visit under the CBRC. DHS expects to receive CMS' final approval shortly. Of the $96.4 million in FY 08-09, $72.8 million represents retroactive payments for FYs 05-06 through 07-08, and $23.6 million is ongoing.

(E) This reflects the Board's approval in August 2008 to adjust the rate on all improved parcels (from $0.03 to $0.0372 per square foot), as adjusted by the cumulative increase to the medical component of the Western Urban Consumer Price Index (CPI) since July 1, 2003. This would generate approximately an additional $45.2 million per year, of which $36.8 million is to be allocated to DHS hospitals to partially offset unreimbursed costs of emergency and trauma services provided to indigents.

(F) This assumes MLK to be converted back to a 120-bed hospital on January 1, 2010. DHS expects to run MLK with 36 Average Daily Census (ADC), half of the estimated annual 73 ADC as stated in Footnote (C), as a phase-in progress for the first 6 months (from January through June of 2010) after the conversion takes place.

(G) This assumes restoration of the $33.0 million MLK appropriation transfer to Provisional Financing Uses (PFU) per Supervisor Molina's motion on June 17, 2008 in regard to MLK MACC services reduction (calculated based on 152,000 patient visits).

(H) This reflects the updated Medi-Cal Redesign revenues model that includes revised data from other public hospitals in the State.

(I) This is based on SB 1100 Medi-Cal administrative day payments which are not part of the Medi-Cal Redesign revenues model.

(J) Beginning in FY 08-09, the amount of money available in Disproportionate Share Hospital (DSH) funds is expected to grow. This amount is calculated based on the Federal statute which uses the CPI of 2.8%.

(K) This is based on revised cost reports including the tentatively approved SPA for CBRC.

(L) This reflects updated estimates due to other revenue offsets higher than originally expected.

(M) This reflects the Plan of Correction for EMTALA Compliant #130751 OV/UCLA received in January 2008 in relation to the patient triage process. The Plan includes: (1) expansion of clinical space at the Department of Emergency Medicine (DEM) - Area II during peak patient arrival hours to reduce waiting times and to more closely align hours of peak resource availability with peak clinical care provision; (2) extension of the hours of operation of the Medical Walk-In Unit from 12 to 16 hours a day to improve Emergency Department flow; and (3) implementation of the Step-Down Unit to improve the medical screening process.

(N) Estimates do not include the following potential items:

i. State issues - Reallocation of County funding ($ in millions) may be needed to fund various State programs:

- Federal Safety Net Care Pool	$ (14.4)
- South Los Angeles Preservation Fund	(10.0)
	$ (24.4)

ii. Coverage Initiative Maintenance of Effort (MOE) - DHS is currently working with the California Department of Health Care Services to develop the County's MOE and the related issue of changing our non-hospital based delivery system. DHS will also work with the State to ensure that the Department can fully utilize the administrative components of the Coverage Initiative program. The financial impact beginning in FY 08-09 is estimated to be $(31.5) million ongoing.

iii. Section 1931(b) Medi-Cal (per Governor's May Revised Budget as of 5/14/08) - The May Revision proposes to roll back the income eligibility level from 100 percent of the Federal Poverty Level (FPL) to 68 percent of the FPL for applicant families who currently qualify for zero share of cost Medi-Cal benefits, and to reinstate the 100-hour rule for these families. In addition, principle wage earners who work more than 100 hours per month would not be eligible for Medi-Cal benefits. The financial impact beginning in FY 08-09 is estimated to be $(5.0) million ongoing.

iv. Medi-Cal eligibility for legal immigrants (per Governor's May Revised Budget as of 5/14/08) - The May Revision proposes to eliminate full-scope benefits for newly qualified immigrants who have been in the United States for less than 5 years and for immigrants who permanently reside under the color of law. The financial impact beginning in FY 08-09 is estimated to be $(1.5) million ongoing.

v. Unused $360 million Waiver funds (State-wide) - The original estimate for the DHS share was $125.0 million. It may potentially be reduced to $97.0 million if the State retains $75.0 million of the $360.0 million. This one-time fund is expected to be available in FY 09-10.

vi. Pending GME regulation disallowing use of Interns & Residents costs for Certified Public Expenditures - The President has extended the current moratorium through March 2009. The financial impact for FYs 08-09 (for April through June 2009) through 11-12 is estimated to be $(10.1) million, $(41.5) million, $(42.8) million, and $(44.1) million, respectively.

vii. Pending Federal rule limiting Medicaid reimbursement to public hospitals to Medicaid cost - This reflects the impact of reduced Safety Net Care Pool funds due to limited availability under the pending Federal rule. The financial impact beginning in FY 10-11 is estimated to be $(228.0) million ongoing.

viii. Additional Managed Care Rate Supplements - The financial benefit is estimated to be $10.0 million for FY 08-09 (for October 2008 through June 2009) and $13.3 million for FY 09-10 and onward.

ix. Medicare revenue changes - This reflects proposed changes to Medicare revenue included in President's Proposed Budget. The effective date is expected to be on October 1, 2008. The financial impact for FYs 08-09 through 11-12 is estimated to be $(6.2) million, $(10.1) million, $(15.8) million, and $(18.5) million, respectively.

x. Revision for the Medi-Cal Inpatient Treatment Authorization Request (TAR) process - DHS and the State DHCS and CMS have proposed an exception to the current TAR process to delegate TAR approval authority to DHS hospitals. DHS and the DHCS have proposed to use the InterQual Case Management program and hospital Utilization Review Committee to approve medical necessity admission and continued stay determinations. The financial impact cannot be determined at this time.

DHS Budget Plan

I. Introduction

This report provides a framework for addressing the financial and programmatic challenges of the Department of Health Services (DHS). These challenges are not new to the County or to DHS, and they are rooted in the fact that the majority of DHS clients are uninsured or underinsured and the on-going funding streams that support their care have not kept up with the cost of providing that care.

Historically, DHS has been successful in obtaining additional State and federal revenues to assist in addressing the funding gap between the demand for uninsured care and available funding. However, these funds have generally been time-limited and have not provided an on-going source of revenue to respond to escalating health care costs and increasing demand.

In the absence of ongoing revenue streams for uninsured care, and/or the ability to achieve revenue maximization and a shared responsibility for the costs of healthcare for the uninsured and underinsured, DHS has few options to align its programs within available resources. The options are, essentially: 1) impose austerity and secure efficiencies; 2) limit the populations that can use the DHS system; and 3) limit the array of services DHS provides.

II. DHS System Redesign – June 2002

The Summer of 2002 was the last time the Board approved major service changes to address the DHS fiscal condition, when it approved the DHS Redesign Plan. That Plan outlined a number of clinical and operational reforms that were proposed to help DHS function better as a health care system, and potentially generate savings from better management of limited resources. The Plan also included service reductions that, while noted as undesirable, were recommended to align service levels with available resources under a "least harm" planning approach.

The following elements of the Plan were implemented:

- $28.4 million reduction through the closure of 11 DHS Health Centers
- $20.1 million in savings through LAC+USC efficiencies
- $15.4 million reduction in administration
- $15.1 million in increased revenue related to psychiatric services
- $15.0 million reduction in the Public Private Partnership (PPP) Program
- $14.7 million in efficiencies at Comprehensive Health Centers
- $10.9 million in reductions in non-rehabilitation services at Rancho
- $9.9 million in savings via the conversion of High Desert Hospital to a Multi-service Ambulatory Care Center (MACC)
- $8.0 million reduction in public health
- $2.3 million in operational savings in the Office of Managed Care
- $0.2 million in efficiencies in Antelope Valley area facilities
- Some clinical consolidations (no savings)

TOTAL SAVINGS IMPLEMENTED: $140 million annually

The following elements were not implemented:

- Reduction of 100 beds at LAC+USC. Reduction barred by courts; proceeding under settlement terms.

- Contracting out certain administrative functions in the DHS Office of Managed Care/Community Health Plan. Action stopped due to business decision by the prospective contractor.
- Restructuring of DHS psychiatric services. Discussions continue with DMH and CEO to reduce service costs or increase revenues.
- Operational efficiencies at MLK/Drew. Reform initiative stopped when priority shifted to addressing quality of care concerns raised by the federal Centers for Medicare and Medicaid Services (CMS).
- Clinical consolidations. Reform initiative stopped due to funding consequences (e.g., consolidation of OB services would result in loss of revenue); other proposals being developed.
- Rancho privatization or closure. Closure was barred by courts; privatization efforts continue consistent with settlement terms.

III. Key Issues since the Last Major Action on the DHS Fiscal Condition

Harris/Rodde Litigation. The LAC+USC and Rancho reductions proposed in the 2002 Plan were challenged in court by patient advocates. As a result of a settlement of these cases, DHS was able to achieve only partial initial savings of $10.9 million, with future savings deferred and contingent on: 1) maintaining a certain level of admissions at LAC+USC, and 2) the County identifying an operator for Rancho. Thus far, only $20.1 million in savings have been implemented at LAC+USC pursuant to the settlement.

MLK Hospital. The inability of DHS to rectify operational performance and maintain quality at MLK has had significant costs. The closure of trauma, emergency room and inpatient care at the facility has impacted patient access to care, and neighboring public and private facilities have absorbed extra service demand.

Significantly, the County was successful in retaining the MLK Medi-Cal inpatient revenues (through SB 474) that would have otherwise flowed to the remaining public hospitals in the County and State.

California Medicaid Hospital Waiver. In 2005, all of the financing for public hospitals in California was reconfigured into a new model called the California Medicaid Hospital Waiver, which runs from July 1, 2005 to June 30, 2010. Approximately $1 billion annually in Medi-Cal funding to the DHS system is affected by the new model.

Under the old model, DHS hospital financing was comprised of Medi-Cal inpatient reimbursement and supplemental payments (known as SB 1255) which were negotiated with the California Medical Assistance Commission, and Disproportionate Share Hospital (DSH) payments which were determined via a statewide formula among eligible public and private hospitals. The new model aggregates these three payments for all public hospitals in California into a single formula which protects each hospital's baseline funding (with certain volume and cost adjustments) and shares any available new funds on a proportionate basis. Unlike the old model where the County could develop new revenues in isolation of other hospitals, the new model has fused together all of the Medi-Cal inpatient funds for all public hospitals into a single formula. This means that a change in the service profile or costs of one public hospital can influence the availability of funds for the remaining public hospitals.

It is important to note that a key financing component of the Hospital Waiver is the Safety Net Care Pool (SNCP), which provides funding to the public hospitals for uncompensated care but

has no growth factor associated. This means that public hospitals have a finite pool of federal funds to share for uncompensated care.

Another component of the Hospital Waiver is the Coverage Initiative, which provides limited funding to certain counties to provide care coordination and expanded services to indigent patients. The net benefit of the Coverage Initiative to DHS is about $31 million annually.

Significantly, $360 million remains available to California under the Hospital Waiver, but the State has deferred action on expanding the use of managed care, a federal requirement to accessing the $360 million. The County and other public hospitals have been urging the State to negotiate with the federal government to gain access to these funds. However, these negotiations have not begun and could be lengthy and difficult.

Lastly, the State will likely begin negotiations with the federal government in 2009 to renew the Hospital Waiver. Among the key issues in the negotiation will be securing a federal growth factor for the SNCP, and extension of the Coverage Initiative. Additionally, the funding formula among the public hospitals will be re-negotiated. Thus, the outcome of DHS' negotiations with the other public hospitals and the outcome of the State's negotiations with the federal government will define the inpatient funding future of DHS hospitals from July 1, 2010 forward.

IV. Current DHS Fiscal Forecast

In our report to your Board on February 15, 2008, the Department estimated shortfalls of $(290.9) million in Fiscal Year (FY) 2008-09 and $(725.4) million in FY 2009-10. Subsequently, on April 22, June 17, and August 8, 2008, the Department provided updated forecasts based on adjustments in revenue projections and additional savings. Some of the adjustments in revenue projections include the Board's approval of a Measure B rate increase with an estimated annual value of $36.8 million, and the recent favorable decision from CMS regarding Cost Based Reimbursement Clinics (CBRC) reimbursement for Medicare/Medicaid crossover (dual eligible) outpatients with an estimated annual value of $22.0 million.

The Department is also estimating cost savings and revenue enhancements of $89.9 million for FY 2008-09 and $89.6 million for FY 2009-10 based on the Financial Stabilization efforts identified in prior reports to your Board. The Financial Stabilization efforts include reductions in pharmaceutical, nurse registry, medical administration, staffing, administrative and information systems costs. Based on the last estimates reported to your Board on August 8, 2008, the shortfalls were $(31.3) million for FY 2008-09 and $(378.7) million for FY 2009-10.

Although the Department has been able to identify various cost savings and revenue enhancements, there continue to be substantial systemic shortfalls. The structural budget deficit continues to persist despite increases in additional County contribution to the Department over the last three fiscal years: a one-time increase of $125 million in FY 2006-07, $86.1 million originally allocated in FY 2006-07 and ongoing (DHS' share of $125 million allocated between DHS and the Department of Public Health), $30 million in FY 2007-08 and ongoing, and one-time Tobacco Settlement funds of $41.6 million in FY 2008-09.

As a result of these actions, the revised deficit forecast for FY 2008-09 is $(43.7) million, pending the impact of State budget cuts. Additional revenues adding up to $34.8 in FY 2008-09 are being actively pursued. The Department will work with the CEO to address the remaining $8.9 million shortfall in FY 2008-09 and any additional adverse impact that may result once the State Budget is passed. Based on State budget impact and any additional changes in revenue projections or efficiencies, the fiscal forecast will be revised and provided to your Board in January 2009.

The revised deficit forecast for FY 2009-10 is $(360.5) million.

It is important to note that the DHS forecast makes the following significant assumptions:

- No change in the revenue formula under the California Medicaid Hospital Waiver. This is estimated to be valued at approximately $1 billion annually in Medi-Cal funding.
- Retention of the MLK Medi-Cal hospital revenues at $100 million per year.
- To the maximum extent possible, funding from the post-MLK closure provided to DHS and private hospitals and MLK MACC operations will be shifted to a re-opened 120-bed MLK Hospital (private or public).
- Assumes the prior Board action regarding Rancho, effective by the end of FY 2008-09. This is equal to $32.6 million annually.
- Payments to other County departments are reduced.
- The new LAC+USC Medical Center is budgeted as a 600-bed hospital, plus 71 off-site psychiatric beds for a total of 671 budgeted beds.
- Assumes cost of living adjustments (COLAs) for salaries and employee benefits and for services and supplies, based on historical experience and projected trends.
- Financial Stabilization cost savings and revenue enhancements in the amount of $89.9 million will be achieved in FY 2008-09.
- Proposed State budget cuts related to SNCP and SB 474 funding are not included pending finalization of the State budget.
- Assumes no increase in County contribution.

As always, the forecast will continue to be revised as new information becomes available.

V. Proposed Budget Plan

The DHS budget plan reflects the following additional revenue solutions and efficiencies in order to address the budget deficit beginning in 2008-09 and continuing into 2009-10. If DHS is successful in achieving these, the Department does not anticipate service reductions in 2008-09. However, if the Department is not successful, or if the State budget curtailments are enacted, DHS will develop service reduction proposals to present to the Board for consideration.

Potential Revenue/Funding Solutions

DHS is currently pursuing potential revenue increases through various sources (see Attachment). For FY 2009-10, these include:

- $28.0 million annually from a Managed Care Rate Supplement
- $13.2 million County contribution for a pharmaceuticals COLA
- $96.8 million in one-time revenue through recapture of Hospital Waiver funds
- $24.0 million in one-time revenue through recapture of unused FY 2007-08 Coverage Initiative funds
- $0.8 million in Medicare/Medi-Cal crossover reimbursement for inpatient days
- $4.0 million annually through full-cost reimbursement from Probation for Juvenile Court Health Services
- $16.5 million annually through full-cost reimbursement from the Sheriff's Department for the provision of medical services to jail inmates
- $34.8 million in rollover funds from FY 2008-09

TOTAL POTENTIAL REVENUE/FUNDING SOLUTIONS: $218.1 million

Efficiencies

Primary Care Restructuring
The "least harm" approach clearly points to taking advantage of any opportunities to provide the current level of services at a reduced cost, prior to making other service cuts that are less easily replaced. Ambulatory care restructuring will allow the department to maintain the current volume of service to indigent patients in a more efficient manner. In addition, strengthening the network with PPP contractors will be critical for positioning DHS for future health care policy and reform proposals.

In February 2008, the department presented a healthcare delivery system reconfiguration plan to your Board. This plan included a recommendation to shift the provision of primary care from County-operated facilities to contracted PPP facilities. At that time, concerns were raised about the timeline of the proposed changes, capacity and infrastructure needs, and potential impacts. As a result, your Board instructed the Chief Executive Officer to return with a more detailed proposed project plan to expand privatization of County clinic services. Work on this has begun and the development of a thoughtful plan will continue over the next few months. The Department will invite the participation by stakeholder groups in the development of the plan. An outline of the plan is as follows:

- Primary care currently provided at DHS Health Centers (HCs) and Comprehensive Health Centers (CHCs) are proposed to be transitioned to the private sector through PPP contracts. Contracting of services provides flexibility over time, as population demographics and departmental needs change. Under restructuring, primary care to indigent patients (up to 232,000 visits) would be provided by Strategic Partner PPP agencies either in the current DHS facilities or at nearby private clinic sites. Individual HCs and CHCs would continue to provide primary care until such time as a qualified PPP is fully prepared to absorb the additional workload from that site and a PPP contract (or amendment) has been approved by your Board. The geographic distribution of services would be maintained. Coverage Initiative (Healthy Way LA) patients would continue to receive services under restructuring; primary care would be provided by PPP clinics. Specialty care and urgent care services would continue to be provided by DHS.

- Primary care to patients with Medi-Cal and other coverage (approximately 43,000 patients, or 137,000 visits) would no longer be provided by DHS. DHS has no legal mandate to provide services to this population and private sector resources are more accessible to covered patients. PPP agencies may also decide to provide care to these patients along with the DHS-reimbursed indigent patient visits. Impacted Community Health Plan (CHP) members would be reassigned to other healthcare providers in the network.

- The transition of primary care from County-operated facilities to PPPs would occur on an incremental basis as individual contracts are negotiated. It is anticipated that the restructuring will take time and it is unlikely that all restructuring can be achieved by July 2009. Approximately half of the total annual savings have been included in the FY 2009-10 estimates.

DHS is conducting an evaluation of PPP capacity and interest in primary care restructuring. Regional differences and potential impacts due to other special circumstances will be carefully considered, and infrastructure needs will be assessed. DHS is working with the Chief Executive Office to identify funds to ensure that capacity development and infrastructure needs are addressed. If fully implemented, the restructuring of primary care is expected to result in a net

savings of $44.7 million annually. In FY 2009-10, the expected savings is approximately $22.3 million.

Decrease Use of Nursing Registries
Nursing registries are used for providing additional nursing coverage during surges, as well as temporarily filling vacancies during shortages. DHS is exploring less costly alternatives such as the use of permanent part-time nurses and in-house nurse registries. The expected annual savings from this decreased use of registries is $5.0 million.

Materials Management/Supply Chain Improvements
DHS will establish system-wide formularies for commonly purchased items, such as sutures, medical prosthetics, etc. Standardization of purchases and negotiation of pricing is anticipated to drive costs down. Additional efforts will focus on evaluating appropriate inventory levels and improving nursing unit level access to inventory data, to eliminate overstocking of supplies. The estimated annual savings related to these efforts is $7.4 million.

TOTAL EFFICIENCY SAVINGS IN FY 2009-10: $34.7 million

As a fiscal strategy, an early start on implementing these efficiencies should be undertaken so as to allow time for careful implementation early enough in the fiscal year to achieve the full value of the savings.

Given that the forecasted deficit is $(360.5) million, achieving the combination of revenues and efficiencies listed above will be required. Even if DHS is successful in achieving all of the above revenues and efficiencies, additional funding or service reductions in the amount of approximately $107.7 million may be necessary to balance the FY 2009-10 budget.

VI. Service Delivery and the Deficit

Balanced DHS System Approach

In adopting the DHS Redesign Plan in June 2002, the County embraced a service delivery approach that would seek to maximize DHS' ability to provide a balanced array of services that are geographically dispersed, and support emergency and trauma care. The 2002 Plan also considered service reform alternatives that were presented to the Board in a January 2002 report entitled the DHS Strategic and Operational Action Plan which is useful in understanding the broad policy options the County could use to fulfill its health care obligations. That report outlined four potential models that the County could use to fulfill those obligations: a contractual model; a highly controlled inpatient model; a defined scope of services model; and a trauma and acute care model.

It is important to note that under any of the options presented, numerous areas of the existing health care system (both public and private) would be impacted by these options. Impacts range from reductions in certain types of services to changes in the DHS-medical school relationships to an increased burden on private sector health care providers, and ultimately decreased access for patients. The potential impacts highlight how DHS is intricately woven into the health care safety net and the overall health care sector in Los Angeles County. Most believe that if DHS were to cease being a direct provider of care, the results would be devastating to the entire health care system in Los Angeles County. The decision to build a new LAC+USC Medical Center, as well as to make other capital investments, demonstrates that the County is committed to continue as a direct safety net provider. As a result, DHS recommended and the Board adopted a future program direction as follows:

An integrated and coordinated system of care for medically indigent and Medi-Cal patients with a balanced program of inpatient, outpatient and emergency services.

The first priority is to continue to explore ways of adopting efficiencies and increasing revenue to the maximum extent possible to avoid service reductions. This approach is recommended due to the timing of the renegotiation of the Hospital Waiver, which may reduce the need for service reductions if new funding becomes available in 2010. However, if after these approaches are implemented there is still not enough funding to meet current service levels, some service reductions may be necessary. These could include the reduction of inpatient services and/or facility closures. These service reductions would have a negative impact on patients as well as on other healthcare providers (both public and private), and are to be avoided if at all possible.

Contingency Reductions

If revenues are not realized and/or no other funding is made available, service reductions will be necessary. Proposed service reductions have been developed and will be presented to the Board for consideration, if needed.

Alternative Approaches for Service Reductions

It is important to note that the balanced system approach is not the only possible model that was considered when planning for reducing the deficit. In 2001 and 2002, the following other options were also considered, but were deemed less acceptable for various reasons:

Hospital-only model: Under this approach, the DHS system would be exclusively hospital based and would cease providing any non-emergency outpatient healthcare services. While this approach focuses the limited DHS resources on the sickest patients, services for uninsured outpatients would be severely limited and would likely result in an increased strain on already overburdened public and private emergency rooms as patients have no other options for care. Fewer people would receive preventive care, which would likely result in an increase in preventable disease burden and high health care treatment costs.

Closure of one or more DHS hospitals: Under this approach, one or more DHS hospitals would be closed. While this would allow for a greater level of cost savings due to reduction of fixed costs, the result would be a major loss of care for any part of the County being served by DHS hospitals. There would also be a regional impact due to some of the specialized services available at DHS hospitals.

Highly controlled inpatient model: Under this approach, DHS hospitals would cease to provide emergency room services as a way to limit services. More than 85% of DHS hospital admissions are derived via the emergency room. Because federal law requires that a hospital with an emergency room cannot limit care to patients unless they are stabilized, such a facility faces extraordinary cost pressures. DHS facilities bear an especially significant pressure because the vast majority of patients seen in public hospital emergency rooms are uninsured or underinsured. If DHS-operated emergency rooms were closed, DHS would have greater control over the number and types of inpatients who are admitted. However, this would severely strain private sector emergency rooms and could lead to closure of some private sector emergency rooms and/or hospitals.

Contracted out model: Under this approach, care would be purchased from private providers for County-responsible patients rather than direct operation of hospitals or clinics. This is the approach used in Orange and San Diego counties, and would allow the County to determine

clearly the patient population and services. Although this approach has many attractive elements, the potential loss of revenue to the safety net is great because most of the Medi-Cal supplemental funding that supports uninsured care in the DHS-operated system could not be transferred into a contracted model without changes in State and federal Medicaid rules.

VII. Implementation Timetable

In order to realize the needed savings for FY 2009-10 and avoid more drastic cuts, efficiencies and service reductions must occur by the beginning of the fiscal year. Therefore, the Department proposes the following timeline:

- September 2008: Proceed with release of RFI for primary care restructuring and development of proposed project plan and impact analysis.
- December 2008: Hold public hearing on the impact of proposed primary care restructuring; submit project plan to Board of Supervisors.
- January 2009: Present updated budget plan for Board action.

Attachment: Solutions for DHS Budget

JF:id 9/12/08

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

SOLUTIONS FOR DHS BUDGET

FISCAL YEARS 2008-09 and 2009-10

(Dollars in Millions)

	FY 2008-09	FY 2009-10
Estimated Cumulative Year-End Fund Balances/(Shortfalls) - 6/9/08	**($213.5)**	**($589.6)**
Revenue initiatives	197.1	285.8
Financial Stabilization updates	9.1	22.1
Adverse impact to Fiscal Outlook	(48.6)	(105.3)
Other	12.2	26.5
Adjusted Beginning Deficit Balance (cumulative)	($43.7)	($360.5)
Potential Revenue/Funding Solutions:		
Managed Care Rate Supplement [1]	$20.0	$28.0
Funding for pharmacies COLA	11.5	13.2
Recapture share of $360M (one time)	-	96.8
Capture unused FY 07-08 Coverage Initiative funds (one time)	-	24.0
Medicare/Medi-Cal Crossover reimbursement for inpatient days [2]	3.3	0.8
Full-cost reimbursement from Probation for JCHS [3]	-	4.0
Full-cost reimbursement from Sheriff for jail beds [4]	-	16.5
Forecast improvement/(reduction) roll forward		34.8
Subtotal Potential Revenue Solutions	**$34.8**	**$218.1**
Deficit Balance After Potential Revenue Solutions [5]	**($8.9)**	**($142.4)**
Efficiencies		
Restructure primary care (discontinue primary care at HCs/CHCs, replace indigent visits via PPPs) [6]	-	$22.3
Materials Management/Supply Chain - standardize purchasing formularies	-	7.4
Decrease the use of nurse registries	-	5.0
Subtotal - Efficiencies	**$0.0**	**$34.7**
Deficit Balance After Revenue Solutions and Efficiencies	**($8.9)**	**($107.7)**

Footnotes:

1) Assumes 50% of these amounts are funded by additional County funds.
2) Medicare/Medi-Cal Crossover reimbursement payment for inpatient days identified in FY 08-09 includes payments for FY 05-06 through FY 08-09.
3) The funding gap for JCHS cost in FY 08-09 is $8.9 million of which $4.9 million has been included in the FY 08-09 forecast.
4) Cost of jail services is $26.5 million. Cost has been reduced by $10.0 million provided by Sheriff for jail services.
5) We will work with the CEO to address the $8.9 million deficit in FY 08-09 and any adverse impact from the State budget. The Fiscal Forecast will be revised to include these issues and will be brought back to the Board in January 2009.
6) Approximately half of the total annual savings of $44.7 million is expected to be achieved in FY 09-10.